MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

5522 — Reg. Dist. No. 05495

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Charlestown
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Charlestown
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Carroll — Middle C. — Last Algard

4. DATE OF DEATH: Month May — Day 7 — Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 16 1883

9. AGE (In years last birthday): 75 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): R.R. Trackman

10b. KIND OF BUSINESS OR INDUSTRY: Ret 9 years

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Valentine B. Algard

14. MOTHER'S MAIDEN NAME: Mary Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: Edna Mae Algard Charlestown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Diabetes Mellitus — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs
260 X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Osteomyelitis Right foot.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 18, 1958 to May 6, 1959 that I last saw the deceased alive on May 6, 1959, and that death occurred at 9:30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Clarence I. Benson M.D. — ADDRESS (Street, city or town, state): Port Deposit, Md. — DATE SIGNED: 5/7/1959

PHYSICIAN'S NAME (Type): CLARENCE I. BENSON

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: May 10, 1959

22c. NAME OF CEMETERY OR CREMATORY: Charlestown

22d. LOCATION (City, town, or county) (State): Charlestown, Cecil Co., Md

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph R. Grant — ADDRESS: North East, Maryland

24a. REC'D BY REGISTRAR DATE: MAY 12 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item4 FilmG243 5/28/59 cap

5523

CERTIFICATE OF DEATH

05496

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Colora
c. LENGTH OF STAY IN 1b: 2 3/4 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (Rural) 2 mi. W of Rising Sun
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CLARENCE Middle B. Last BAUGHMAN

4. DATE OF DEATH: Month May Day 12 17 Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan 2, 1900
9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10b. KIND OF BUSINESS OR INDUSTRY: Home Builder
11. BIRTHPLACE (State or foreign country): Glady Fort, W. Va
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: John Baughman
14. MOTHER'S MAIDEN NAME: Elizabeth Baughman, Colora Md

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 214-01-7963
17. INFORMANT — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Adenocarcinoma of lung
163X
DUE TO
(b):
DUE TO
(c):

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

INTERVAL BETWEEN ONSET AND DEATH: 6 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 1958 to 5/12 1959 that I last saw the deceased alive on 5/11 1959, and that death occurred at 12:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Neil Taylor M.D.
ADDRESS (Street, city or town, state): Rising Sun, Maryland
DATE SIGNED: 5/13/59
PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5/14/59
22c. NAME OF CEMETERY OR CREMATORY: West Nottingham
22d. LOCATION (City, town, or county) (State): Colora, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Ralph M Reed, Rising Sun, Md

24a. REC'D BY REGISTRAR DATE MAY 14 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5524

CERTIFICATE OF DEATH

05497

Reg. Dist. No. 96

1

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2

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1. PLACE OF DEATH a. COUNTY: Cecil MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: District of Columbia b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point c. LENGTH OF STAY IN 1b: 11 days	c. CITY OR TOWN (If outside carporote limits, write RURAL ond give nearest tawn): Washington 47X-3
d. NAME OF HOSPITAL (If nat in haspital, give street address) OR INSTITUTION: Veterans Adm. Hospital 050	d. STREET ADDRESS: 1335 Corcoran St. N.W. e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	VERNON	H.	BELL		May	24	19 59

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Negro		March 17, 1905	54 yrs.				

10a. USUAL OCCUPATION (Give kind af wark done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Checker	Mobile Equipment Highway Dept. DC	Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Martin Bell	Carrie I. Watts

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	INFORMANT Address
Yes	WW II	577 26 0695	Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatoblastoma with metastases to the lymph — INTERVAL BETWEEN ONSET AND DEATH: unknown

156.1

DUE TO (b) nodes around the celia axis about the pancreas and the hilum of the liver

Conditions, if ony, which gave rise to immediate couse (a), stoting the underlying couse last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at wark ☐ Nat while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that VA attended the deceased from May 13, 19 59, to May 24, 19 59 [illegible] and that death occurred at 7:15 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): V.A.Hospital, Perry Point, Md. — DATE SIGNED: 5-25-59

PHYSICIAN'S NAME (Type): J. L. GAREY — Clinical Pathologist

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
REMOVAL	5/26/59	Arlington National	Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Pennington & Son, Havre de Grace, Md.	MAY 28 '59	Arthur S. Murphy

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

5503 — Reg. Dist. No. 05498

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elk ton
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 2/ Elkton
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Linda — Middle: Susan — Last: Billings

4. DATE OF DEATH: Month: May — Day: 20, — Year: 19 59

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 11, 1954

9. AGE (In years last birthday): 4 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ------

10b. KIND OF BUSINESS OR INDUSTRY: ----------

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Chester L. Billings, Sr.

14. MOTHER'S MAIDEN NAME: Gertrude G. Seymour

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): ------
(If yes, give war or dates of service): ------

16. SOCIAL SECURITY NO.: ----------

17. INFORMANT — Address: Mrs. Gertrude Billings, Elkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Chronic Glomerulo nephritis — INTERVAL BETWEEN ONSET AND DEATH
592 X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 19____, to 20 May, 19 59, that I last saw the deceased alive on 19 May, 19 59, and that death occurred at 2 30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Clifton R. Brooks, M.D.
ADDRESS (Street, city or town, state): 269 E. Main Street, Newark, Del
DATE SIGNED: 5/20/59

PHYSICIAN'S NAME (Type): Clifton R. Brooks

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: May 22/59
22c. NAME OF CEMETERY OR CREMATORY: Cherry Hill Cemetery
22d. LOCATION (City, town, or county) (State): Cherry Hill, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Ralph E. Hicks
ADDRESS: Elkton, Md.
24a. REC'D BY REGISTRAR DATE: MAY 27 '59
24b. REGISTRAR'S SIGNATURE: Clinton S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5525 **CERTIFICATE OF DEATH** Reg. Dist. No. 05499

1. **PLACE OF DEATH**
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Nottingham, R.D.1
c. LENGTH OF STAY IN 1b: 10 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Graybeal Nursing Home

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Perryville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First JESSE Middle T Last BLACKSON

4. **DATE OF DEATH**: Month 5-8 Day Year 19 59

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 1876

9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: All kinds work

11. BIRTHPLACE (State or foreign country): Perryville, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: AARON BLACKSON

14. MOTHER'S MAIDEN NAME: MARY MAHAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 218-18-4975

INFORMANT Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Myocarditis
DUE TO
(b): Atherosclerosis
DUE TO
(c):

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I attended the deceased from May 1st, 1959, to 5-8-59, 19__, that I last saw the deceased alive on 5-8-59, 19__, and that death occurred at 3 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: R.C. Dodson M.D. ADDRESS (Street, city or town, state): Rising Sun, Md. DATE SIGNED: 5-9-59

PHYSICIAN'S NAME (Type): R.C. Dodson

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5-11-59

22c. NAME OF CEMETERY OR CREMATORY: Principio

22d. LOCATION (City, town, or county) (State): Principio Furnace, Cecil Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Lee A. Patterson & Son Perryville, Md.

24a. REC'D BY REGISTRAR DATE: MAY 12 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05500

5526 **CERTIFICATE OF DEATH**

Reg. Dist. No. 96

1. **PLACE OF DEATH** a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 16yrs.14days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: Wyoming — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Eden
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐ Unknown

87x-3

3. **NAME OF DECEASED** (Type or print): First PAUL — Middle (NMI) — Last BOGATAJ

4. **DATE OF DEATH**: Month May — Day 7 — Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-24-94

9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miner

10b. KIND OF BUSINESS OR INDUSTRY: Coal

11. BIRTHPLACE (State or foreign country): Jugoslavia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO.: unknown

INFORMANT Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia bilateral unresolved — INTERVAL BETWEEN ONSET AND DEATH: 4-5 days
420.0
DUE TO
(b): Arteriosclerotic heart disease
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerosis generalized severe

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year 19 VA

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 28, 1943, to May 7, 1959 ~~xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx~~ and that death occurred at 8:40a M, from the causes and on the date stated above.

ACTUAL SIGNATURE: J. L. Garey M.D. — ADDRESS (Street, city or town, state): V.A. Hospital, Perry Point, Md. — DATE SIGNED: 5-8-59

PHYSICIAN'S NAME (Type): J. L. GAREY — Clinical Pathologist

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 5/15/59

22c. NAME OF CEMETERY OR CREMATORY: Baltimore National

22d. LOCATION (City, town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Pennington & Son, Havre de Grace, Md.

24a. REC'D BY REGISTRAR DATE: MAY 18 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5527 — Reg. Dist. No. 05501

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton, R.D.
c. LENGTH OF STAY IN 1b: all life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Del. — b. COUNTY: NewCastle
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Newark, & Christiana
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Franklin — Middle: Stanley — Last: Bryan
4. DATE OF DEATH: Month: 5 — Day: 13 — Year: 19 59
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4-23-1922
9. AGE (In years last birthday): 37 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver
10b. KIND OF BUSINESS OR INDUSTRY: Private
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: George S, Bryan
14. MOTHER'S MAIDEN NAME: Helen Bullock
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes, give war or dates of service): W.W.2
16. SOCIAL SECURITY NO.: 217-18-3759
17. INFORMANT — Address: Mrs. Helen Bullock, Townsend. Del.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pistal bullet in center of Forehead — INTERVAL BETWEEN ONSET AND DEATH:
975 X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Shot self after shooting wife
20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year: 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) Elkton, R.D. (County) Cecil (State) Md

21. I certify that I taak charge af the remains described abave, held an Autapsy ☐, Inspectian ☒, Inquiry ☒ and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒ Hamicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: R.C. Dodson M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 5-14-59
EXAMINER'S NAME (Type): R.C.Dodson

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: May 17, 1959
22c. NAME OF CEMETERY OR CREMATORY: North East Cemetery
22d. LOCATION (City, town, or county) (State): North East Cecil Md.
23. FUNERAL DIRECTOR'S SIGNATURE: Joseph R Grant — ADDRESS: North East Md
24a. REC'D BY REGISTRAR — DATE: MAY 20 '59
24b. REGISTRAR'S SIGNATURE: Arthur L Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5528

Reg. Dist. No. 05502

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rising Sun
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Harvy Wharf - North East

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore 3Vol-4
d. STREET ADDRESS: 126 Market Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Berkley; Middle:; Last: Butler
4. DATE OF DEATH: Month: May; Day: 24; Year: 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☑
8. DATE OF BIRTH: Feb. 16, 1930
9. AGE (In years last birthday): 29 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CLERK
10b. KIND OF BUSINESS OR INDUSTRY: Gen. Electric Co.
11. BIRTHPLACE (State or foreign country): BALTO Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: ALBERT C. BUTLER
14. MOTHER'S MAIDEN NAME: ~~MARY C. BUTLER~~ Cecelia Butler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 217-24-3891
17. INFORMANT: 110 S. Culver St. Address: MRS. MARY CECELIA HINKEL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxia due to drowning
929.8
DUE TO (b):
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Found floating in water
20c. TIME OF INJURY: Hour a. m. p. m. May 20 1959
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): River
20f. (City or town) (County) (State): Rising Sun Cecil Maryland

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Charles S Petty M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
DATE SIGNED: 5/24/59
EXAMINER'S NAME (Type): Charles S. Petty

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: May 26, 1959
22c. NAME OF CEMETERY OR CREMATORY: Mount Olivet Cem.
22d. LOCATION (City, town, or county) (State): Balto. Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: E. Truman Lehnert
ADDRESS: 3512 Frederick Ave. (27)
24a. REC'D BY REGISTRAR DATE: MAY 26 '59
24b. REGISTRAR'S SIGNATURE: Arthur J. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

5529

Reg. Dist. No. 05503

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Cecilton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Cecilton
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First CHARLES Middle HENRY Last BYERLY Jr.

4. DATE OF DEATH: Month May Day 10, Year 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: March, 27, 1889

9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Florist

10b. KIND OF BUSINESS OR INDUSTRY: Florist

11. BIRTHPLACE (State or foreign country): Philadelphia, Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Henry Byerly, I

14. MOTHER'S MAIDEN NAME: Fannie Gest

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 197-12-0690

17. INFORMANT: Mrs. Anna Byerly, Address: Cecilton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gastro-intestinal hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days
181.0
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.
(b) Metastatic urinary bladder carcinoma — 7 years
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): senility

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 1954, 19____, to May 10, 19 59, that I last saw the deceased alive on May 10, 19 59, and that death occurred at 8:00a M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wallace Obenshain M.D. ADDRESS (Street, city or town, state): Cecilton, Md. DATE SIGNED: 11 May 59

PHYSICIAN'S NAME (Type): Wallace Obenshain, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: May, 12, 1959

22c. NAME OF CEMETERY OR CREMATORY: Arlington, Cemetery

22d. LOCATION (City, town, or county) (State): Philadelphia, Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: Edward Fellows ADDRESS: Millington Md.

24a. REC'D BY REGISTRAR DATE: MAY 12 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05504

5504

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Delaware
b. COUNTY: New Castle
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Newark
d. STREET ADDRESS: 5 Phillips Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Harry F. Middle Cavender Last
4. DATE OF DEATH: Month May Day 15, Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 17, 1881
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Delaware
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph Cavender
14. MOTHER'S MAIDEN NAME: Sadie Moore

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unknown (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Florence M. Cavender — Address: 5 Phillips Ave. Newark, Delaware

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Rupture of gall bladder — INTERVAL BETWEEN ONSET AND DEATH: 18 hours
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Cholelithiasis + Cholecystitis — unknown
DUE TO
(c):

584X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Obesity + Gen Arteriosclerosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5-14, 1959, to 5-15, 1959, that I last saw the deceased alive on 5-14, 1959, and that death occurred at 605A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Williford Eppes M.D. — ADDRESS (Street, city or town, state): 325 E. Main St — DATE SIGNED: 5-15-59
PHYSICIAN'S NAME (Type): Williford Eppes — Newark Del

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: May 18, 1959
22c. NAME OF CEMETERY OR CREMATORY: Bethel Cem.
22d. LOCATION (City, town, or county) (State): Bethel, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: K. T. Jones — ADDRESS: Newark Del
24a. REC'D BY REGISTRAR DATE: MAY 19 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

Obesity + Gen Arteriosclerosis

Cholelithiasis + Cholecystitis 2 m Known

Rupture of gall bladder 18 Years

Milford Hynes	Newark Del	5-13-54
Medical Comp	325 E. Main St	
5-14 54	5-14 54	5-16 54

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5530 CERTIFICATE OF DEATH

Reg. Dist. No. 05505 96

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 5 Mo. 28 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington D. C.
d. STREET ADDRESS: 2 47x-3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First JOHN; Middle; Last CLARK

4. DATE OF DEATH: Month 5; Day 26; Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6-17-1900

9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): Unknown

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Michael Gilligen (Dec.)

14. MOTHER'S MAIDEN NAME: Elizabeth Clark (Dec.)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
If yes, give war or dates of service: Peace Time

16. SOCIAL SECURITY NO.: None

INFORMANT: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): BRONCHOPNEUMONIA, BILATERAL, UNRESOLVED. — INTERVAL BETWEEN ONSET AND DEATH: 4 To 5 Days
DUE TO
(b): CARCINOMA, RECURRENT, SITE OF LARYNGECTOMY, — Unknown
DUE TO
(c): WITH EROSION INTO THE LEFT CAROTID VESSEL

Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.

161X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m.

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8-31-34, 19____, to 5-26-, 1959 [illegible] and that death occurred at 5:30 P.M., from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL SIGNATURE, M.D.: S. P. Lacerva

PHYSICIAN'S NAME (Type): S.P. LACERVA, M.D. — VA HOSPITAL, PERRY POINT, MARYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
22b. DATE THEREOF: 6/1/59
22c. NAME OF CEMETERY OR CREMATORY: Balto. Md.
22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible]
ADDRESS: [illegible], Havre de Grace, Md.

24a. REC'D BY REGISTRAR DATE: JUN 3 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5505 Liber 321 Folio 254 12/30/59 1012 05506

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY: Cecil — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Cecil
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton — c. LENGTH OF STAY IN 1b: 3 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Devine Haven Nursing Home	d. STREET ADDRESS — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First: Dr.	Middle: Clarence	Last: B. Collings Jr.	4. DATE OF DEATH	Month: May	Day: 29	Year: 19 59		
5. SEX: Male	6. COLOR OR RACE: white	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH: 12-4-1883	9. AGE (In years last birthday): 75 yrs.	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.			

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Medical Doctor	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country): TEXAS	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Clarence B.Collings Sr.		14. MOTHER'S MAIDEN NAME: Louise N. Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: none	17. INFORMANT: Louise C.Fitch Address: Jacksonville Florida	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: unknown

422.1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from October 6, 1956, to May 29, 1959, that I last saw the deceased alive on May 28, 1959, and that death occurred at 8:06a M, from the causes and on the date stated above.

ACTUAL SIGNATURE: S. Ralph Andrews, Jr., M.D. — ADDRESS (Street, city or town, state): 233 E. Main St. Elkton, Maryland — DATE SIGNED: May 29, 1959

PHYSICIAN'S NAME (Type): S. Ralph Andrews, Jr., M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	June 1, 1959	Methodist	North East, Cecil Co., Md

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Joseph R. Grant North East, Maryland	JUN 3 '59	Arthur S. Travis

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

5506 — Reg. Dist. No. 05508

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 21 Elkton
d. STREET ADDRESS: 148 W. Main St. ~~Union Hosp.~~
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JO — Middle ANN — Last DUNLAP
4. DATE OF DEATH: May 23, 1959

5. SEX: F.
6. COLOR OR RACE: W.
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 16, 1959
9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months — Days 7 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ------
10b. KIND OF BUSINESS OR INDUSTRY: ------
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Carroll M. Dunlap
14. MOTHER'S MAIDEN NAME: Katherine Simpers

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Father — Address: Elkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 7 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 756.2
(b): Possible Biliary Atresia — 7 days
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 16 May, 1959, to 23 May, 1959, that I last saw the deceased alive on 23 May, 1959, and that death occurred at 7:05 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: George J. Kreis Jr. M.D. — ADDRESS (Street, city or town, state): Elkton, Md. — DATE SIGNED: 5/25/59

PHYSICIAN'S NAME (Type): George J. Kreis

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5/25/1959
22c. NAME OF CEMETERY OR CREMATORY: Gilpin Manor Memorial
22d. LOCATION (City, town, or county) (State): Park Elkton, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: PIPPIN FUNERAL HOME — ADDRESS: Donald M. Dee Elkton, Md.
24a. REC'D BY REGISTRAR DATE: JUN 1 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be carried with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/SS

2065233XVI

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5531 — 05509 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryville
c. LENGTH OF STAY IN 1b: all life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Aiken Ave

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Perryville
d. STREET ADDRESS: Aiken Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Edith	C	Edwards	5	7	1959

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
F	W		12-20-1899	59 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Perryville Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Ward	Mary Chamberlain

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
no	220-30-5674	Nancy Edwards. Perryville. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: R.C.Dodson M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 5-8-59

EXAMINER'S NAME (Type): R.C.Dodson

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	5-9-1959	Principio Cemetery	Principio Furnace, Md.

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Kell & Patterson & Sons	Perryville, Md.	MAY 11 '59	Arthur L Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Cecil

Maryland

Cecil

Perryville

all life

Perryville

Aiken Ave

Aiken Ave

Smith

C

Edwards

F

59

12-20-1899

x

Housewife

Perryville Md.

U.S.A.

John Baro

Mary Chamberlain

no

220-30-5674

Nancy Edwards, Perryville, Md.

Acute Coronary Occlusion

x

x

x

ox

R.C. Dodson

x

5-8-59

Burial

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5507

CERTIFICATE OF DEATH

Reg. Dist. No. 05510

1. PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: CECIL

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
c. LENGTH OF STAY IN 1b: 10 Days
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Chesapeake City

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: UNION HOSPITAL
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Thomas Middle: Leroy Last: Foard

4. DATE OF DEATH: Month: May Day: 11 Year: 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7/21/1888

9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Store-keeper

10b. KIND OF BUSINESS OR INDUSTRY: Sales

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas J. Foard

14. MOTHER'S MAIDEN NAME: Eva Cummings

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Myrtle V. Foard Address: Ches. City, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 3 mos

177X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Metastatic Carcinoma of Prostate — 3 years.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Senility

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 9, 19 59 to May 11, 19 59, that I last saw the deceased alive on May 11, 19 59, and that death occurred at 4:05 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Wallace Obenshain M.D. ADDRESS (Street, city or town, state): Cecilton, Md. DATE SIGNED: 12 May 59

PHYSICIAN'S NAME (Type): Wallace Obenshain

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5/14/1959
22c. NAME OF CEMETERY OR CREMATORY: Bethel Cemetery
22d. LOCATION (City, town, or county) (State): Nr. Chesapeake City, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: PIPPIN FUNERAL HOME ADDRESS: Donald M. Pippin Elkton, Md.

24a. REC'D BY REGISTRAR DATE: MAY 14 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be [illegible] for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

5532

Reg. Dist. No. 05512

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): rural - Calvert Md.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Nottingham Pa.
d. STREET ADDRESS: R D 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bertie Middle: D. Last: Swaltney

4. DATE OF DEATH: Month: May Day: 1 Year: 1959

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept 24 1882

9. AGE (In years last birthday): 76 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Rugby, Tuscon Co Va

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Joseph Reedy

14. MOTHER'S MAIDEN NAME: Jane Shelton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Address: Viola Swaltney, Nottingham R. 1. Pa

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arthritis Deformans — INTERVAL BETWEEN ONSET AND DEATH: 15 years

723.0

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from —, 1950 to May 1, 1959, that I last saw the deceased alive on May 1, 1959, and that death occurred at 9 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: J. B. Robinson M.D. ADDRESS (Street, city or town, state): — DATE SIGNED: May 2 1959

PHYSICIAN'S NAME (Type): —

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: May 4 1959

22c. NAME OF CEMETERY OR CREMATORY: Oxford Cem.

22d. LOCATION (City, town, or county) (State): Oxford - Chester Co Pa

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Ralph M Reed, Rising Sun, Md

24a. REC'D BY REGISTRAR DATE MAY 5 '59

24b. REGISTRAR'S SIGNATURE: Arthur L Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: [redacted] after this certificate has been signed by the attending physician and completely filled in by the [redacted] al director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5508 **CERTIFICATE OF DEATH**

05511
Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Earleville
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First HOWARD — Middle — Last GREEN

4. DATE OF DEATH: Month May — Day 13, — Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May, 13, 1880
9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Green
14. MOTHER'S MAIDEN NAME: Mollie Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 213-26-6403A
17. INFORMANT: Mrs. Mary E. Husfelt, — Address: Earleville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebro-vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 15 hours
331X
DUE TO (b): cerebral arteriosclerosis — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 13 May, 1959 to 13 May, 1959, that I last saw the deceased alive on 13 May, 1959, and that death occurred at 4:30p M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wallace Obenshain M.D. — ADDRESS (Street, city or town, state): Cecilton, Md. — DATE SIGNED: 16 May 59

PHYSICIAN'S NAME (Type): Wallace Obenshain, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: May 17, 1959
22c. NAME OF CEMETERY OR CREMATORY: Sudlersville Cemetery
22d. LOCATION (City, town, or county) (State): Sudlersville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edward Fellows — ADDRESS: Millington, Md.

24a. REC'D BY REGISTRAR DATE: MAY 20 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5509

Reg. Dist. No. 05513

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 1 Hr.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A. Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: N. Y. — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): New York 69x-3
d. STREET ADDRESS: Sullivan St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First KITTY — Middle HOLLAND — Last
4. DATE OF DEATH: Month 5 — Day 17 — Year 19 59

5. SEX: F.
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 5, 1900
9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: at Home
11. BIRTHPLACE (State or foreign country): London, England
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Harris Marcus
14. MOTHER'S MAIDEN NAME: Fannie Marcus

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Evelyn Greenburg — Address: Kerhounkson, N.Y.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH
260X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Diabetes
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: R. C. Dodson M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: May 17, 1959
EXAMINER'S NAME (Type): R. C. Dodson

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 5/17/ 1959
22c. NAME OF CEMETERY OR CREMATORY: Wellwood Cemetery
22d. LOCATION (City, town, or county) (State): Pinelawn, N. Y.

23. FUNERAL DIRECTOR'S SIGNATURE: PIPPIN FUNERAL HOME
ADDRESS: Elkton, Md.
24a. REC'D BY REGISTRAR DATE MAY 21 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kruse

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5510 CERTIFICATE OF DEATH

Reg. Dist. No. 05514

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Earleville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

065

3. NAME OF DECEASED (Type or print): First MARY — Middle E. — Last HUSFELT

4. DATE OF DEATH: Month May — Day 23, — Year 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June, 13, 1882

9. AGE (In years last birthday) 76 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Davis

14. MOTHER'S MAIDEN NAME: Laura Biggs

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Frank Husfelt, — Address: Earleville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Congestive Failure — Interval between onset and death: 4 hours.

443X

DUE TO (b): Hypertensive Cardio-vasular Disease — Interval: years

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Acute mesenteric Thrombosis - 12 hours before death

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

0

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May, 1954, to May 23, 1959, that I last saw the deceased alive on May 23, 1959, and that death occurred at 7:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Wallace Obenshain M.D. — ADDRESS (Street, city or town, state): Cecilton, Md — DATE SIGNED: 25 May 59

1

PHYSICIAN'S NAME (Type): WALLACE OBENSHAIN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: May, 26, 1959

22c. NAME OF CEMETERY OR CREMATORY: Cecilton Cemetery

22d. LOCATION (City, town, or county) (State): Cecilton, Cecil Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edward Tellous — ADDRESS: Millington, Md.

24a. REC'D BY REGISTRAR DATE: MAY 28 '59

24b. REGISTRAR'S SIGNATURE: Wilson H. Travers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5533 CERTIFICATE OF DEATH

05515
Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the local director, page 3 should be signed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY: Cecil — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Cecil
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East c. LENGTH OF STAY IN 1b: Lifetime	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X North East
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION	d. STREET ADDRESS / e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
James	G.	Jones	May	26	1959

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	white		11-2-1880	78 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Gardner	Veg. Raising	Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Samuel Jones	Emma Priest

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
no	none	Mrs Ernest Demond	North East, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Coronary Thrombosis	5 min.
420.1 — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	Hypertensive Arteriosclerotic Cardiovascular Disease	15 years
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. / Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
—		—	—

21. I **certify** that I attended the deceased from May, 1946, to 26 May, 1959, that I last saw the deceased alive on 22 May, 1959, and that death occurred at 8 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Klaus H. Hoehne M.D. — ADDRESS (Street, city or town, state): North East Md — DATE SIGNED: 27 May '59

PHYSICIAN'S NAME (Type): Klaus H. Hoehne M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	May 29, 1959	Methodist	North East, Cecil Co., Md

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Joseph R. Grant North East, Maryland	JUN 1 '59	Carlton L. Evans

1

Item 1 FilmG242 5-18-59 et

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

5511

Reg. Dist. No. 05516

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ELKTON Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rock Hall
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Edith — Middle E. — Last Kelley

4. DATE OF DEATH: Month 5 — Day 8 — Year 1959

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 5/7/1894

9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): U.S. MARYLAND

12. CITIZEN OF WHAT COUNTRY? Yes USA

13. FATHER'S NAME: Edward Jenkins

14. MOTHER'S MAIDEN NAME: Anna Crowley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Virginia Warner — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: unknown

422.1

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Profound anemia, cause undetermined; generalized arthritis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year, Hour o. m. / p. m. 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 2, 1959, to May 7, 1959, that I last saw the deceased alive on May 7, 1959, and that death occurred at 6:23 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: S. Ralph Andrews Jr. M.D.

ADDRESS (Street, city or town, state): 233 E. Main Street

DATE SIGNED: May 7, 1959

PHYSICIAN'S NAME (Type): S. Ralph Andrews, Jr., M.D. — Elkton, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 5/10/59

22c. NAME OF CEMETERY OR CREMATORY: Wesley Chapel

22d. LOCATION (City, town, or county) (State): Rock Hall Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Colgan & Son — ADDRESS: Church Hill

24a. REC'D BY REGISTRAR DATE: MAY 12 '59

24b. REGISTRAR'S SIGNATURE: Carlton S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5512 **CERTIFICATE OF DEATH** Reg. Dist. No. 05517

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 317 W. Main Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 21 Elkton
d. STREET ADDRESS: 317 W. Main Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Katie; Middle: ; Last: Marcus

4. DATE OF DEATH: Month: May; Day: 25; Year: 1959

5. SEX: F.

6. COLOR OR RACE: W.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Jan. 16, 1885

9. AGE (In years last birthday): 74 yrs.

IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House-wife

10b. KIND OF BUSINESS OR INDUSTRY: at Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Bullen

14. MOTHER'S MAIDEN NAME: Ida Woodrow

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mr. William H. Marcus Address: Elkside, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Myocardial Infarct
420.1
DUE TO
(b): Coronary Sclerosis
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cathracts; Carcinoma of cervix

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 19 53, to May 25, 19 59, that I last saw the deceased alive on May 25, 19 59, and that death occurred at 7:10 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Milford H. Sprecher M.D. ADDRESS (Street, city or town, state): 125 W. Main, Elkton, Md. DATE SIGNED: May 26

PHYSICIAN'S NAME (Type): Milford H. Sprecher

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5/28/1959

22c. NAME OF CEMETERY OR CREMATORY: Gilpin Manor Memorial Park

22d. LOCATION (City, town, or county) (State): Elkton, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: W. H. PIPPIN FUNERAL HOME ADDRESS: Elkton, Md.

24a. REC'D BY REGISTRAR DATE: JUN 1 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5513 CERTIFICATE OF DEATH

05518
Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Chesapeake City
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: I. Middle: Day Last: McCauley
4. DATE OF DEATH: Month: May Day: 12, Year: 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: March 16, 1877
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Agent
10b. KIND OF BUSINESS OR INDUSTRY: Insurance
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: James T. McCauley
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 217-03-5519
17. INFORMANT: David R. McCauley, Elkton, Md. (Address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Adenocarcinoma of Colon with metastasis — INTERVAL BETWEEN ONSET AND DEATH: 4 1/2 years
153.8
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) —
DUE TO
(c) —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): —
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19 —
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —
20f. (City or town) (County) (State) —

21. I certify that I attended the deceased from March, 1955, to 12 May, 1959, that I last saw the deceased alive on 12 May, 1959, and that death occurred at 12:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Klaus H. Huebner M.D.
ADDRESS (Street, city or town, state): North East, Md.
DATE SIGNED: 12 May '59
PHYSICIAN'S NAME (Type): KLAUS H. HUEBNER

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5/15/59
22c. NAME OF CEMETERY OR CREMATORY: Cherry Hill Cemetery
22d. LOCATION (City, town, or county) (State): Cherry Hill, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Ralph E. Hicks
ADDRESS: Elkton, Md.
24a. REC'D BY REGISTRAR DATE: MAY 20 '59
24b. REGISTRAR'S SIGNATURE: Arthur J. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05519

5534 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton R.D.3
c. LENGTH OF STAY IN 1b: all life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Elkton R.D.3.
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First Nora — Middle B. — Last Mendenhall

4. DATE OF DEATH: Month 5 — Day 27 — Year 19 59

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: -1-5-1874

9. AGE (In years last birthday): 85 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Housewife

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Joseph B. Yerkes

14. MOTHER'S MAIDEN NAME: Mary Erwin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: -------

17. INFORMANT — Address: Mrs. James F. Allen, Carrcroft. Wil. Del.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Aterscherosos extreme and nephritis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.1
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 1956, 19____, to 5-18-59, 19____, that I last saw the deceased alive on 5-18-59, 19____, and that death occurred at 6 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R.C.Dodson M.D. — ADDRESS (Street, city or town, state): Rising Sun, Md. — DATE SIGNED: 5-28-59

PHYSICIAN'S NAME (Type): R.C.Dodson, M.D. — Rising Sun, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5-31-59

22c. NAME OF CEMETERY OR CREMATORY: Rosebank

22d. LOCATION (City, town, or county) (State): Calvert Cecil, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Ralph E. Hicks / Elkton, Md

24a. REC'D BY REGISTRAR — DATE: JUN 4 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5514 CERTIFICATE OF DEATH

Reg. Dist. No. 05520

1. PLACE OF DEATH
a. COUNTY: Cecil
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 1 Month
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
d. STREET ADDRESS: 208 Park Circle
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ANNA Middle MAY Last MENGES

4. DATE OF DEATH: Month May Day 30 Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 15, 1898
9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retail
10b. KIND OF BUSINESS OR INDUSTRY: Sales
11. BIRTHPLACE (State or foreign country): Delaware
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: William R. Heavellow
14. MOTHER'S MAIDEN NAME: Daisey Money

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 222-01-8083
17. INFORMANT: William R. Edmanson Address: Elkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Clear cell carcinoma of renal origin — INTERVAL BETWEEN ONSET AND DEATH: about 1 yr.
180X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 28, 1959 to May 30, 1959, that I last saw the deceased alive on May 30, 1959, and that death occurred at 3:20p M, from the causes and on the date stated above.

ACTUAL SIGNATURE: S. Ralph Andrews, Jr. M.D.
ADDRESS (Street, city or town, state): 233 E. Main St.
DATE SIGNED: May 30, 1959
PHYSICIAN'S NAME (Type): S. Ralph Andrews, Jr., M.D. Elkton, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/2/1959
22c. NAME OF CEMETERY OR CREMATORY: Bethel Cemetery Nr.
22d. LOCATION (City, town, or county) (State): Chesapeake City, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: PIPPIN FUNERAL HOME Donald M. Lee
ADDRESS: Elkton, Md.
24a. REC'D BY REGISTRAR DATE JUN 4 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 shall be filed with the registrar for use as the burial-transit permit. Then please remove carbon papers.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5535 · CERTIFICATE OF DEATH

Reg. Dist. No. 05521 96

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 51 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattesville, 16 15-2
d. STREET ADDRESS: 3607 Longfellow St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
BERT	P.	MEYEN	May	9	1959

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White		Oct. 4, 1894	64 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Guard	Unknown	Omaha, Nebraska	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Paul Meyen	Pauline Schwag

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	INFORMANT Address
Yes	WWl	Unknown	Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia, left lung — INTERVAL BETWEEN ONSET AND DEATH: 3 days

420.0

DUE TO (b) Arteriosclerotic heart disease — Unk.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Carcinoma right lung, removal 4-17-59

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 19, 19 59, to May 9, 19 59, that I last saw the deceased alive on [illegible], and that death occurred at 2:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): V. A. Hospital, Perry Point, Md. — DATE SIGNED: 5-10-59

PHYSICIAN'S NAME (Type): J. L. GAREY — Clinical Pathologist

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
	5/15/59	Arlington National	Ft. Myer, Virginia.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
PENNINGTON & SONS, Havre de Grace, Md.	MAY 20 '59	Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5515 **CERTIFICATE OF DEATH** 05522

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EIKTON
c. LENGTH OF STAY IN 1b: 24 hrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: UNION HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: DELAWARE
b. COUNTY: NEW CASTLE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NEWARK 46 x 3
d. STREET ADDRESS: 18 AUGUSTA Rd Chestnut Hill
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

066

3. NAME OF DECEASED (Type or print): First WILLIAM Middle — Last Powell

4. DATE OF DEATH: Month 5 Day 21 Year 1959

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: 8-25-1881

9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MILLWORKER

10b. KIND OF BUSINESS OR INDUSTRY: FIBRE

11. BIRTHPLACE (State or foreign country): DELAWARE

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: — Powell

14. MOTHER'S MAIDEN NAME: MARY Voshell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 222-07-8207

17. INFORMANT: Richard Aiken — Address: 18 Augusta Rd Newark Dela

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 10 hrs
DUE TO
(b): Hypertensive Vascular Disease — Un Known
DUE TO
(c):

331 x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 5-21, 1959, to 5-21, 1959, that I last saw the deceased alive on 5-21, 1959, and that death occurred at 10:30 A.M., from the causes and an the date stated above.

ACTUAL SIGNATURE: Williford Eppes M.D. — ADDRESS (Street, city or town, state): 325 E Main Street — DATE SIGNED: 5-21-59

PHYSICIAN'S NAME (Type): Williford Eppes — Newark, Delaware

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 5-24-59

22c. NAME OF CEMETERY OR CREMATORY: Newark Methodist

22d. LOCATION (City, town, or county) (State): Newark Dela.

23. FUNERAL DIRECTOR'S SIGNATURE: William J Warwick — ADDRESS: Newark Dela

24a. REC'D BY REGISTRAR DATE MAY 25 '59

24b. REGISTRAR'S SIGNATURE: Corinna S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5516 CERTIFICATE OF DEATH

Reg. Dist. No. 05523

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 9 Days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL ond give nearest town): Elkton
d. STREET ADDRESS: 21 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Howard Middle Rodney Last Purner
4. DATE OF DEATH: Month May Day 11 Year 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 2, 1957
9. AGE (In years last birthday) --- yrs. IF UNDER 1 YEAR Months 9 Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ------
10b. KIND OF BUSINESS OR INDUSTRY: ---------
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? ------
13. FATHER'S NAME: Rodney Purner
14. MOTHER'S MAIDEN NAME: Rachel Miller
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Father Address: Chesapeake City, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Atelectasis & Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
762.5
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Prematurity
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Prematurity
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 2, 1959 to May 11, 1959 that I last saw the deceased alive on 11 May, 1959, and that death occurred at 1:02 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Wallace Obenshain M.D. ADDRESS (Street, city or town, state): Cecilton, Md. DATE SIGNED: 11 May 59

PHYSICIAN'S NAME (Type): Wallace Obenshain

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5/13/1959
22c. NAME OF CEMETERY OR CREMATORY: Bethel Cemetery
22d. LOCATION (City, town, or county) (State): Nr. Chesapeake City, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: PIPPIN FUNERAL HOME Donald M. Pippin Elkton, Md.
24a. REC'D BY REGISTRAR DATE: MAY 14 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Price

2065262XV2

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5517 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

05524
Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Elkton, R.D.3.
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Minnie — Middle: — Last: Rattenbury

4. DATE OF DEATH: Month: 5 — Day: 17 — Year: 19 59

5. SEX: F — 6. COLOR OR RACE: W — 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-3-1874

9. AGE (In years last birthday): 85 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired T, Nurse
10b. KIND OF BUSINESS OR INDUSTRY: Nursing
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Rattenbury
14. MOTHER'S MAIDEN NAME: Katherine Ewing

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Union Hospital Records, Elkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ~~Fractured of neck left femur~~ 904.0
DUE TO (b): Hypostatic Pneumonia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fell in her home
20c. TIME OF INJURY: Hour 11 p. m. — Month, Day, Year: 5 59 '59
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) Elkton, R.D.3 (County) Cecil (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: R.C. Dodson M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 5-17-59

EXAMINER'S NAME (Type): R.C. Dodson

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 5-20-1959
22c. NAME OF CEMETERY OR CREMATORY: St MARY ANN EPISCOPAL
22d. LOCATION (City, town, or county) (State): NORTH EAST Md

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph R Grant — ADDRESS: North East, Md
24a. REC'D BY REGISTRAR — DATE: MAY 22 '59
24b. REGISTRAR'S SIGNATURE: Arthur S Kinnard

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5518

05525 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Elk Mills
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: George — Middle: Franklin — Last: Rutter
4. DATE OF DEATH: Month: 5 — Day: 22 — Year: 19 59

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12-31-1901
9. AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Auto Parts
10b. KIND OF BUSINESS OR INDUSTRY: Chrysler Corp?
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Daniel Rutter
14. MOTHER'S MAIDEN NAME: Elizabeth Davis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 211-07-7244
17. INFORMANT — Address: Mrs. Anna M Rutter, ElkMills, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH:
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: R.D. Dodson M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 5-23-59
EXAMINER'S NAME (Type): R.D. Dodson

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5-25-59
22c. NAME OF CEMETERY OR CREMATORY: Cherry Hill Cem.
22d. LOCATION (City, town, or county) (State): Cherry Hill Cecil Md.

23. FUNERAL DIRECTOR'S SIGNATURE: PIPPIN FUNERAL HOME Donald M. Lee — ADDRESS: ELKTON MD
24a. REC'D BY REGISTRAR DATE: MAY 26 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Hines

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5519 CERTIFICATE OF DEATH

Reg. Dist. No. 05526

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 70 Yrs.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 416 North Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 21 Elkton
d. STREET ADDRESS: 416 North Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First LEWIS Middle A. Last SeTh

4. DATE OF DEATH: Month 5 Day 17 Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Sept. 13, 1882
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Realtor
10b. KIND OF BUSINESS OR INDUSTRY: Sales
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lewis Seth
14. MOTHER'S MAIDEN NAME: Lena Carr

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 218-12-6789
17. INFORMANT: W. Andrew Seth Address: Elkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CEREMIA Carcinoma Fracture — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs
DUE TO (b): C.V.A. — 2 mos
DUE TO (c): Diabetes Mellitus & Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 29 March, 1959, to 17 May, 1959, that I last saw the deceased alive on 5/17/59, 19___, and that death occurred at 2:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: George J. Kries M.D. ADDRESS (Street, city or town, state): Elkton, Md. DATE SIGNED: 5/19/59

PHYSICIAN'S NAME (Type): George J. Kries

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: May 21, 1959
22c. NAME OF CEMETERY OR CREMATORY: Gilpin Manor Memorial Park
22d. LOCATION (City, town, or county) (State): Elkton, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: PIPPIN FUNERAL HOME Donald M. Pippin ADDRESS: Elkton, Md.
24a. REC'D BY REGISTRAR DATE: MAY 25 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kinna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5520 — 05527 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: all life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 182 Hollingsworth Manor

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 21 Elkton
d. STREET ADDRESS: 182 Hollingsworth Manor
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Milford — Middle: Ayres — Last: Simmons
4. DATE OF DEATH: Month: 5 — Day: 17 — Year: 1959
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2-2-1907
9. AGE (In years last birthday): 52 yrs.
IF UNDER 1 YEAR: Months: Days: — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bar Tender
10b. KIND OF BUSINESS OR INDUSTRY: Saloon
11. BIRTHPLACE (State or foreign country): Elkton, Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Wesley Simmons
14. MOTHER'S MAIDEN NAME: Mary Elizabeth Sick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): W.W.2
16. SOCIAL SECURITY NO.: 216-01-4590
17. INFORMANT: Mrs. Milford A. Simmons, Elkton, Md. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Perforating bullet 25 caliber wound in right temple — INTERVAL BETWEEN ONSET AND DEATH
976X
DUE TO (b): and made exit left side of head.
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Shot self with 25 caliber automatic revolverin the right temple
20c. TIME OF INJURY: Hour: 10.25 o. m. p. m. — Month, Day, Year: 5 17 19 59
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) Elkton (County) Cecil (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: R.C. Dodson M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 5-17-59
EXAMINER'S NAME (Type): R.C. Dodson

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 5/20/59
22c. NAME OF CEMETERY OR CREMATORY: ELKTON CEMETERY
22d. LOCATION (City, town, or county) (State): ELKTON, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: TIPPIN FUNERAL HOME — ADDRESS: Elkton Md.
24a. REC'D BY REGISTRAR — DATE: MAY 21 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Turner

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the [redacted] Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05528

5536

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 2mos.6 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre DeGrace
d. STREET ADDRESS: 300 Bourbon
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROLAND — Middle A. — Last TYSON

4. DATE OF DEATH: Month May — Day 29, — Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: 11-2-90

9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JAMES TYSON

14. MOTHER'S MAIDEN NAME: ELIZABETH HUMPHREY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW-I

16. SOCIAL SECURITY NO.: Unknown

INFORMANT: Hospital Records, VAH., Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Bronchopneumonia acute & chronic with pul-	Several weeks
DUE TO	monary edema	
(b)	Arteriosclerotic heart disease with marked	unknown
DUE TO	coronary sclerosis	
(c)	Primary carcinoma of lung	unknown

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Pulmonary fibrosis & emphysema

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 23, 1959, to May 29, 1959, that I last saw the deceased [redacted], and that death occurred at 3:25A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: B. S. Linn — M.D. — ADDRESS (Street, city or town, state): V.A. Hospital, Perry Point, Md. — DATE SIGNED: 5-29-59

PHYSICIAN'S NAME (Type): B. S. LINN

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 6/3/59

22c. NAME OF CEMETERY OR CREMATORY: Arlington National

22d. LOCATION (City, town, or county) (State): Ft. Myer, Virginia.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: PENNINGTON & SON, Havre DeGrace, Md.

24a. REC'D BY REGISTRAR DATE: JUN 9 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5537 — 05529 — Reg. Dist. No. 96

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 2 mo. 10 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: New Jersey — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Burlington 67x3
d. STREET ADDRESS: 122 E. Pearl Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: RICHARD — Middle: (NMI) — Last: VANLEER
4. DATE OF DEATH: Month: May — Day: 1 — Year: 1959

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Unknown
9. AGE (In years last birthday): 65? yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: unknown
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Walter Vanleer
14. MOTHER'S MAIDEN NAME: Mary Robinson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW I
16. SOCIAL SECURITY NO.: unknown
17. INFORMANT — Address: Hospital Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchopneumonia unresolved — INTERVAL BETWEEN ONSET AND DEATH:
900.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b): Cerebral hemorrhage right side, subdural
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fell down cellar steps.
20c. TIME OF INJURY Hour XXXX p. m. — Month, Day, Year: 2-19, 59
20d. INJURY OCCURRED While at work ☒ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) (County) (State): Burlington, New Jersey

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: R. C. Dodson M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 5-1-59
EXAMINER'S NAME (Type): R. C. DODSON

22a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
22b. DATE THEREOF: 5/14/59
22c. NAME OF CEMETERY OR CREMATORY: Beverly National
22d. LOCATION (City, town, or county) (State): Beverly, New Jersey

23. FUNERAL DIRECTOR'S SIGNATURE: Pennington & Son
ADDRESS: Havre de Grace, Md.
24a. REC'D BY REGISTRAR DATE: MAY 7 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

5521

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05530

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 4 hurs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Del. — b. COUNTY: New Castle
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Delaire 46 x 3
d. STREET ADDRESS: 107 Sunset Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First James — Middle L — Last Vaughan
4. DATE OF DEATH: Month 5 — Day 23 — Year 19 59
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 8-5-1889
9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Effeciency Ret.
10b. KIND OF BUSINESS OR INDUSTRY: Dupont Co.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James H. Vaughan
14. MOTHER'S MAIDEN NAME: Sarah Layman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): none
16. SOCIAL SECURITY NO.: 146-09-6754
17. INFORMANT — Address: James L. Vaughan, Jr. 107 Sunst Drive, Del.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY — Hour — Month, Day, Year — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: R.C.Dodson M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED
EXAMINER'S NAME (Type): R.C.Dodson — 5-23-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5-27-59
22c. NAME OF CEMETERY OR CREMATORY: Bethel Cemetery,
22d. LOCATION (City, town, or county) (State): nr. Chesapeake City, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Joseph R Grant, North East Md.
24a. REC'D BY REGISTRAR — DATE: MAY 27 '59
24b. REGISTRAR'S SIGNATURE: Arthur L Kraus

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05531

CERTIFICATE OF DEATH

5538 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East
c. LENGTH OF STAY IN 1b: 10 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X North East
d. STREET ADDRESS: 1 Main
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Stanley Middle: Nartin Last: Williams Sr.

4. DATE OF DEATH: Month: May Day: 15 Year: 1959

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: December 25, 1908

9. AGE (In years last birthday): 50 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: DuPont Chestnut Run

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jesse C. Williams

14. MOTHER'S MAIDEN NAME: Addie England

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mabel Barr Williams Address: North East, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Hours

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Coronary Sclerosis — 3 months
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 12, 1959, to May 14, 1959, that I last saw the deceased alive on May 14, 1959, and that death occurred at 12.05A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Clarence H Benson M.D. ADDRESS (Street, city or town, state): Port Deposit, Md. DATE SIGNED: May 13 1959

PHYSICIAN'S NAME (Type): CLARENCE I. BENSON

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: May 18, 1959

22c. NAME OF CEMETERY OR CREMATORY: Hopewell

22d. LOCATION (City, town, or county) (State): Port Deposit Rd Cecil Co., Md

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph R. Grant ADDRESS: Joseph R. Grant North East, Maryland

24a. REC'D BY REGISTRAR DATE: MAY 20 '59

24b. REGISTRAR'S SIGNATURE: Mabel L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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